

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32321

State File No. _____

Registrar's No. _____

Registration District No. 367

Primary Registration District No. 6241

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Rural Concordia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

CHARLES W. HUMPHREY

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE

4. Sex M. 5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife AVA HUMPHREY

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased January 28 1895
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 5
If less than one day hr. _____ min. _____

9. Birthplace London
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Silvery Humphrey
13. Birthplace London
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Wood
15. Birthplace London
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. Humphrey Jr.

(b) Address Desloge Mo

17. (a) Funeral (b) Date thereof Aug 5 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New London

18. (a) Signature of funeral director C. J. Boyer

(b) Address Desloge Mo

19. (a) 8-10-43 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Washington
(c) City or town Rural Concordia
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. New London
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 3 year 1943 hour one minute AM

21. I hereby certify that I attended the deceased from June 25, 1943, to June 25, 1943; that I last saw him alive on June 25, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma, anastoid region Right

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 55

Major findings: Of operations none

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) none

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? L (Specify type of place) (c) Means of injury L

23. Signature W. B. Buckmaster (M. D. or other) MD

Address Desloge Mo Date signed 8-4-43

Duration 1 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 4
District File Number 943-27
Date Filed 9-16-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. 1671

P. O. Address Desloge MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. oct
Registrar's No. _____

Registration District No. 367

Primary Registration District No. 6246

1. PLACE OF DEATH:
(a) County Washington
(b) City or town Rural Concord Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Charles Wm Humphrey
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 28 1908
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 1 If less than one day, _____ min.

9. Birthplace Indiana (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-30 (b) (Emily Yeagur)
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1943 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ above on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

32821